

Recovery Pathways, LLC

Substance Use Disorder Treatment Agreement

Patient Name _____ Date _____

Substance Use Disorder treatment is used to improve what you are able to do each day without the use of narcotics/drugs. Along with Medication Assisted Treatment, other medical care will be prescribed to help improve your ability to do daily activities. This will include psychological counseling and may also include exercise, use of non-narcotic analgesics, receipt of case management services, and the use of other therapies or treatment. I understand that compliance with the following guidelines is important in continuing addiction treatment at Recovery Pathways.

Initial each item in the space provided indicating you have read and agree to the following:

1. _____ I understand that I will have the following responsibilities:
 - a. I will take medications only at the dose and frequency as prescribed and at the time of day directed
 - b. I will not increase/change medications without the prior approval of a Recovery Pathways, LLC physician
 - c. I will actively participate in Substance Use Disorder counseling as medication is not enough
 - d. I will not request any Opioid (including Tramadol), Benzodiazepine, or Buprenorphine (i.e. Suboxone) from any other physician
 - e. I will inform Recovery Pathways, LLC of **all** medications that I am taking
 - f. I will obtain **all** medications from one pharmacy and consent to Recovery Pathways, LLC obtaining information from State mandated prescription monitoring programs (MAPS)
 - g. I will protect my prescriptions and medications. Lost prescriptions/medications **will not be replaced**. Running out of medications early will not be compensated.
 - h. I will keep all medications away from children as exposure may cause death.
 - i. I have been advised that a lock box is the best option for storing my medications and it is my responsibility to obtain a lock box and store my medications this way.
 - j. I agree to participate in psychiatric or psychological assessments, if necessary.
 - k. I will not use illegal medications/substances, street drugs, other person's prescriptions, marijuana (medical or otherwise), or alcohol nor will I allow anyone to use/take my prescriptions.
 - l. Illegal, rude, or disruptive behaviors **will not** be tolerated and will result in termination.
 - m. Failure to take Buprenorphine as directed - this includes mixing it with other substances/medications (especially Benzodiazepines) may result in death. I agree to take my medication only as prescribed.
2. _____ I understand that I will consent to random drug screening. A drug screen is a laboratory test in which a sample of my urine, saliva, or blood is checked to see what drugs I have been taking. I agree not to tamper with this test. Tampering can result in immediate termination. I understand lab fees are separate from Recovery Pathways service fees, and I am financially responsible for these drug screens.
3. _____ I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment. I must keep my appointment in order to receive prescriptions. If I do not cancel with 24 hour notice I understand I may be charged a \$25 fee that my insurance will not cover. I must pay this fee before being seen again.
4. _____ I understand if any emergency treatment is needed, Recovery Pathways, LLC should be contacted and the problem will be discussed with the emergency room or other treating physician. I am responsible to notify other providers that I am on Buprenorphine/Naltrexone and not seek narcotic medications from them. I am responsible to bring a copy of the records to my next appointment.

Recovery Pathways, LLC

Substance Use Disorder Treatment Agreement

5. _____ I understand that Recovery Pathways, LLC may stop providing Medication Assisted Treatment or change/discontinue my treatment plan if:
- a. I do not show any improvement in my addiction treatment.
 - b. My behavior is inconsistent with the responsibilities outlined in #1.
 - c. I give, sell, share, or misuse my medication.
 - d. I develop rapid tolerance or loss of improvement from the treatment.
 - e. I obtain Suboxone, buprenorphine, opioids, or benzodiazepines from another doctor.
 - f. I refuse to cooperate when asked to get a drug screen or tamper with the efficacy of my drug screen.
 - g. If a pain problem is identified as a result of prescribed treatment.
 - h. If I am unable to keep follow-up appointments.
 - i. If no contact with the office is made within 30 days
6. _____ If my treatment plan is changed or discontinued, I understand the following:
- a. Recovery Pathways, LLC is not obligated to provide me with a taper of any medication prescribed here should treatment be terminated for any stated reason. I may be offered “comfort medications” to help manage withdrawal symptoms, and/or may be referred to another treatment program to resume care
 - b. All restarts are subject to medical director approval.
 - c. If I choose to have my discharge reviewed/appealed I will submit my request orally or in writing within 45 days to the Rights Advisors identified on the Know Your Rights brochures/poster located in the lobby.
7. _____ I understand there are the following risks and side effects to Medicated Assisted Treatment:
- Buprenorphine/Naloxone Medication Assisted Treatment**
 - a. Mixing Buprenorphine with other substances, including alcohol, benzodiazepines, or sedatives, may worsen the following risks and side effects
 - b. Buprenorphine can cause Physical dependence – this means that abrupt stopping of Buprenorphine may lead to withdrawal symptoms characterized by one or more of the following:
Runny Nose, Difficulty sleeping for several days, Diarrhea, Abdominal cramping, Sweating, “Goose bumps”, Nervousness, Rapid Heart Rate
 - c. Buprenorphine can cause Psychological dependence – this means it is possible that stopping Buprenorphine will cause me to miss or crave it.
 - d. Problems with pregnancy – I will discuss with my physician if I am pregnant or contemplating pregnancy.
 - Naltrexone Medication Assisted Treatment**
 - a. I must let all providers know I am on Naltrexone, especially if considering any type of surgery
 - b. Problems with pregnancy – I will discuss with my physician if I am pregnant or contemplating pregnancy
 - c. Mixing Naltrexone with other substances (opioids, benzodiazepines, alcohol, illicit substances, etc.) can be dangerous and I must abstain from all opioids, benzodiazepines, alcohol, and illicit substances.
 - d. Naltrexone DOES NOT cause dependence, however, abrupt discontinuation of treatment may lead to the return of psychological cravings for substances I was previously dependent on

I have read this document or have had it read to me, I understand it, and have had all my questions answered satisfactorily. I consent to the use of Medication Assisted Treatment to help control my addictive behaviors and I understand that my Medication Assisted Treatment will be carried out as described above.

Patient Signature

Date

Witness Signature

Date